Voicing opposition to "apartheid" is, in most sectors of South African society, as prudent and fashionable as it is outside South Africa.

It is unfortunate that the South African newspapers referred to by Mr Bennun are unavailable to most *BMJ* readers. A reading in toto of each of the articles referred to does not in fact give the same impression of maltreatment and malpractice produced by Mr Bennun's extracts.[5–8] Also, in the case of the trial of Mr Motaung, although Mr Bennun refers to the *Rand Daily Mail* of 28 and 29 July 1982, and the *Sowetan* of 29 July, he does not refer to their 30 July issues. On this date, the *Rand Daily Mail* reported the judge to have summed up: that the accused had lied about the extent of his injuries and the pain he had suffered; that his bullet wounds were not that serious; that the security police had not deliberately kept him from seeing a doctor or sending him to hospital; that his demeanour in the witness box was thoroughly unsatisfactory; and that he had fabricated his evidence.[9] According to the *Sowetan*, the judge found the accused to have been a shrewd person in the witness box and quoted the district surgeon as saying that one shot had grazed the accused's private parts and that he had also suffered a superficial wound.[10] The events giving rise to the trial consisted of multiple killings, attempted killings, and attacks on police and power stations by a gang armed with AK-47 rifles, TNT explosives, and hand grenades.[5]

Mr Bennun is making a sociolegal study of the application of South African security laws. This is, I imagine, a feasible undertaking because of the wealth of independent newspaper reporting and reliable documentation of open court hearings, a set of circumstances now unique in Africa. Without being entirely rhetorical, may I ask Mr Bennun how he would do a similar study of African Commonwealth countries? What would be the sources of one's research material?

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[1] Schulman A. Medical ethics and political ideology. *S Afr Med J* 1982;61:420.
[2] Benatar SR. The death of Dr Neil Aggett. *S Afr Med J* 1982;61:300.
[3] Benatar SR. Medical ethics and political ideology. *S Afr Med J* 1982;61:420.
[4] Schulman A. Medical ethics and political ideology. *S Afr Med J* 1982;61:688.
[5] Mojapelo J. Treason accused "begged" for hospital treatment. *Rand Daily Mail* 1982;July 28:2.
[6] Mojapelo J. Wounded man had to have op, terror trial told. *Rand Daily Mail* 1982;July 29:2.
[7] Nkomo M, Sapa. "Cops first and then medicine." *Sowetan* 1982;July 29:3.
[8] Anonymous. Actor Bingo claims assault. *Post (Transvaal)* 1980;May 8:6.
[9] Mojapelo J. Treason trial accused a liar, says judge. *Rand Daily Mail* 1982:July 30:2.
[10] Nkomo M. Court rejects trialist's claims. *Sowetan* 1982;July 30:2.

**This correspondence is now closed.—ED, *BMJ*.

Medical defence societies

SIR,—The phenomenal escalation in the annual subscription to the medical defence societies continues unchecked. Over the past 25 years the premium has risen from £4 to £264, more than 6500%, much of the increase being over the past five years. The societies themselves must be aware of their high subscription rates as they are now offering monthly payment facilities and "association membership" terms.

The only way to reduce excessive charges is by competition. At present there is none. Membership of a society is virtually compulsory for most doctors, and both organisations are together in a monopoly. Now surely is the time for the general insurance companies to enter the lucrative medicolegal market, but no doubt the General Medical Council would have to give its blessing first. Can the BMA do nothing to accelerate this process?

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**In the years 1976-7 the BMA discussed the possibility of establishing a professional indemnity insurance scheme open only to members of the BMA.[1] The association's annual representative meeting decided, however, to seek closer cooperation with the medical defence societies and to suspend consideration of a professional indemnity scheme for BMA members. The BMA has not formally debated the question since then.[2]—ED, *BMJ*.

[1] British Medical Association. Annual Report of Council 1976-7. *Br Med J* 1977;i:1096.
[2] British Medical Association. Annual Representative Meeting. Professional indemnity insurance. *Br Med J* 1977;ii:478.

South London Hospital for Women

SIR,—The medical news item about the closure of the South London Hospital for Women (19 November, p 1561) reports only the official Department of Health and Social Security view of the matter, in which the distinction between fact and opinion is blurred.

We do not accept that closure "will" save £5m a year. That sum is the Wandsworth Health Authority's figure for the total cost of running the hospital. The authority's statement that compulsory redundancies are not expected, coupled with Lord Glenarthur's statement that staff costs in the NHS account for 75% of revenue costs,[1] suggest that on this score alone a saving of £5m is a gross overestimate.

In addition, the Wandsworth Health Authority's financial report for 1982-3 states that at St George's Hospital the cost for each inpatient case is £1052·81 and for each new outpatient £179·62. The costs for the same categories at the South London Hospital are £801·53 and £86·26 respectively. Given the difference between the costs at the two hospitals, the South London's 5076 inpatients plus the 10 720 new outpatients (for the year 1982) represent notional savings of £2 276·16 on the cost they would have incurred had they been treated at St George's. Although we appreciate the many fallacies of so simplistic a calculation, no interpretation of these figures can avoid the conclusion that closure of the South London will make treatment of its would-be patients substantially more expensive. The same conclusion was reached in the DHSS document on national average costs 1981-2, which shows that hospitals with 101-300 beds are consistently and appreciably less costly than those of over 300 beds.

As regards the workload the facts are as follows. In 1982 new outpatients attending the gynaecological department at the South London numbered 3674, which is 456 more than the sum total of those attending St George's and St James's (and there has been a substantial increase at South London during 1983). Similarly, new patients attending the department of genitourinary medicine numbered 1953, outnumbering the total at St George's and St James's by 1219. We do not know whether the Minister for Health fully appreciates the size of the influx that he is "satisfied" can be absorbed: we do know that before it can even begin certain capital work is necessary, including building a new gynaecological theatre and a new day care unit at St James's Hospital. The cost of this capital work, which it is "hoped" will not exceed £2m, is incidental to the (partial) reprovision of the current facilities at the South London Hospital: it is not part of the £20m phase IIA programme at St George's, the pursuance of which is the prime reason for closing the South London. (Here we note that a central feature of phase IIA is the replacement of an old block, currently in efficient use, and is not a response to a shortage of facilities in the district. Indeed, one of the reasons given for shutting the South London is overprovision of acute beds in the district.)

The provision of improved services for the mentally ill has appeared with monotonous regularity and varying degrees of credibility as a reason for hospital closures, last cited in November by the Bloomsbury Health Authority in support of proposals to close "eight or even ten small hospitals" in the district.[2] There is considerable difference of expert opinion on how the service to the mentally ill should be improved; it would seem wise to resolve this difference before £7·5m (obtained by closing the South London) is committed to redeveloping Springfield. Many authorities equate improvement with closing long stay wards and shutting the mental hospitals.

Now that "the total proceeds of land and property sales will normally return to the disposing district"[3] (rather than to central funds) we suggest that no small hospital on a valuable site can feel safe, especially in a district that is overspent or has great ambitions.

The South London Hospital's special contribution to the public is to provide the opportunity for women to be treated by women doctors and nurses in single sex wards. The minister's assurance that "wherever possible" the patients will be given the choice of being treated by a woman doctor is meaningless in practice when less than 1% of general surgeons and only 11% of all consultants are women. Transfer of the current consultant staff of the South London to other hospitals within the district may for the time being provide a better than average opportunity for patients to see a woman consultant but there is little chance of her supporting staff being all female and some chance of the patient's being nursed by men in mixed sex wards. In short, closure will eliminate the existing choice for women to be treated solely by members of their own sex. It will also eliminate that unique liaison and cooperation that is so striking a feature of the hospital.

That this is not what the public wants has been made abundantly clear by their overwhelming support (60 000 have queued to sign a petition against closure) and by the support of the women's national organisations.

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[1] Lord Glenarthur. Debate on National Health Service. *House of Lords Official report (Hansard)* 1983 November 9;444:col 812 (No 30).
[2] Fletcher D. Job threat in merger plan for hospitals. *Daily Telegraph* 1983 Nov 18:11 (cols 1-2).
[3] South West Thames Regional Health Authority. *Planning guidance*. London: South West Thames RHA, 1983:7.

Correction

Enteritis and colitis associated with mefenamic acid

We regret that an error occurred in the letter from Dr M S Phillips and others (26 November, p 1626). The fourth line of the seventh paragraph should have read "with no malabsorption of fat in the fourth" and not "with malabsoption of fat in the fourth."